

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004856

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 338 Primary Registration District No. 6148 Registrar's No. 42

STATE FILE NUMBER

FILED JAN 28 1963

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Castor Twp.</u>		Length of stay in lb <u>9 years</u>	c. CITY OR TOWN <u>Bernie</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Ann</u> Last <u>Lewis</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>17</u> Year <u>1963</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1875</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid in County Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Harrison, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Tom Cantrell</u>		13b. MOTHER'S MAIDEN NAME <u>Charolette Williams</u>		14. NAME OF HUSBAND OR WIFE <u>deceased</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>XXXXXX</u>	17. INFORMANT <u>Fred Honeycutt</u>	Address <u>Bernie, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from <u>1-10-63</u> to <u>one visit</u> and last saw her alive on <u> </u> Death occurred at <u>6:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Ralph Rehm, M.D.</u> (Print name or title)	22b. ADDRESS <u>Bloomfield Mo.</u>	22c. DATE SIGNED <u>1-21-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-19-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sycamore Cemetery</u>	23d. LOCATION (City, town, or county) <u>Dexter, Mo. Rural</u> (State)
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24. FUNERAL DIRECTOR <u>Watkins & Sons</u>	ADDRESS <u>Dexter, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u> </u>	26. REGISTRAR'S SIGNATURE <u> </u> <u>1-22-63</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

40.30

2 10.30

3

4 1

5 2

6

7 1

8 2

9 420.1

10

11

12 86-0

13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

OWN EMBAL CERTIFICATE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Marsh Watkins

Licensed Embalmer No. _____

4717

P. O. Address _____

Dexter Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.